

Rev. 5-17-39
1-1-1951

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED SEP 19 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28625
Registrar's No. 16

Registration District No. 355

Primary Registration District No. 5497

1. PLACE OF DEATH:

(a) County Henry
(b) City or town North Davis Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 46 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME Jacob Christen
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex m 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Berta Schwenker 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 11 1865
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 21
If less than one day _____ hr. _____ min.

9. Birthplace Switzerland
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER
12. Name Christen
13. Birthplace Switzerland 7
(City, town, or county) (State or foreign country)
14. Maiden name Schwenker
15. Birthplace Switzerland 7
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Berta Christen
(b) Address Montrose Mo

17. (a) Removal (b) Date thereof Aug 5 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Highland Ill.

18. (a) Signature of funeral director Spale & Son
(b) Address Clinton Missouri

19. (a) 8-4-40 (b) W.E. Baggerly
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town rural
(If outside city or town limits, write "RURAL")
(d) Street No. near La Rue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1881 - 59 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3
year 1940 hour 8 minute 20 P. M.

21. I hereby certify that I attended the deceased from July 26, 1940, to August 2, 1940
that I last saw him alive on August 2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia (hypostatic)
Due to: Chronic myocarditis
Due to: _____
Other conditions (Include pregnancy within 3 months of death) ASC

Duration

2 days

PHYSICIAN

Major findings: none
Of operations: none
Of autopsy: none

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 3/17

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature S.B. Hughes (M. D. or other) M.D.
Address Clinton, Mo Date signed Aug 3/40

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1231

Date Filed 9-4-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

W. A. Carisart

Licensed Embalmer No. 3779

P. O. Address Clinton Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.